NEVADA STATE ATHLETIC COMMISSION
555 E. WASHINGTON AVENUE, SUITE 1500
LAS VEGAS, NV 89101
TELEPHONE (702) 486-2575 FACSIMILE (702) 486-2577

OPHTHALMOLOGICAL EXAM

FOR PROFESSIONAL BOXER/UNARMED COMBATANT

TO BE PERFORMED WITH DILATION & BY AN OPHTHALMOLOGIST ONLY

_____ / ___ / _____
Full Name: First Middle Last Ringname (Telephone) Date of Birth

_____
Address (street) (city) (state) (zip code)

HISTORY - If possible provide the following information:

Name and hometown of physician in charge: _____

Has applicant ever had any of the following conditions:

(1) Blurred vision ? ☐ Yes ☐ No

(2) Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye ? ☐ Yes ☐ No

(3) Has applicant ever been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma, aphakia, pseudophakia, dislocated lens, or cataract?
☐ Yes ☐ No If yes, please explain: _____
_____

(4) Eye Disease? ☐ Yes ☐ No
List nature of diseases or injuries: _____

(5) Eye Injury? ☐ Yes ☐ No
List nature of diseases or injuries: _____

(6) Detached retina surgery on either eye? ☐ Yes ☐ No
List which eye and when and where surgery was done: _____
_____
_____

EXAMINATION

VISION: Without / With Glasses
Right _____ / _____
Left _____ / _____

REFRACTION: If either eye is 20/40 or worse:
Right _____ Sph ____ Cyl x _____ Acuity _____
Left _____ Sph ____ Cyl x _____ Acuity _____

Remarks: _____
_____
_____
_____

Intraoccular Tension Right _____ mmHg
Left _____ mmHg
Motility Normal ___ Abnormal _____
Binocular Vision Normal ___ Abnormal _____

SLIT LAMP EXAM	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Conjunctiva			
Cornea	____/____	____/____	
	____/____	____/____	
Iris/Pupil	____/____	____/____	
Lens	____/____	____/____	
Eyelids	____/____	____/____	

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

	NORMAL Right/Left	ABNORMAL Right/Left	SPECIFY ABNORMALITIES
Disc	____/____	____/____	
Macula	____/____	____/____	
Vessels	____/____	____/____	
Peripheral Retina	____/____	____/____	

(PLEASE READ AND SIGN ON REVERSE SIDE OF EXAM)

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REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER/UNARMED COMBATANT BY AN OPHTHALMOLOGIST

PHYSICIAN'S REMARKS: _____

_____

_____

The commission shall deny, suspend, revoke, or place restrictions on the license of a professional or amateur boxer or martial arts fighter because of a medical or visual condition, including but not limited to one of the following:

1) ***Uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes;***
2) ***Corrected visual acuity of less than 20/60 in either eye, regardless of its cause;***
3) ***A visual field of 60 degrees or less extending over one or more quadrants of the visual field;***
4) ***Presence or history of retinal detachment or retinal tear unless treated by an ophthalmologist and then approved by an ophthalmologist specified by the commission who then assesses that the boxer is at no significant risk of further injury to the retina if boxing is resumed. Such assessment shall occur both within five days before and five days after the contest;***
5) ***Presence of primary or secondary glaucoma, whether or not such condition has been treated;***
6) ***Presence of aphakia, pseudophakia, dislocated lens or cataract in either eye;***
7) ***Any other visual condition which the commission determines would prevent the applicant or licensee from safely engaging in boxing activities.***

The examining physician is requested to mail a copy of any report, directly to the commission of an applicant that has a condition that may preclude him/her from being licensed.

PHYSICIAN:

I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on the other side of this form and I ☐ DO NOT FIND ☐ DO FIND a condition that would preclude him/her from being licensed as a ☐ professional boxer, or an ☐ unarmed combatant.

_____ _____

LICENSED PHYSICIAN'S NAME AND LICENSE NUMBER (please print) PHYSICIAN'S SIGNATURE

_____ _____

STREET ADDRESS DATE

_____ (_____) _____

CITY STATE ZIP CODE PHONE NUMBER

APPLICANT:

I declare under penalty of perjury under the laws of the State of Nevada, that the foregoing information is true & correct; further I realize that any intentional misrepresentation may result in disciplinary action against my license.

I hereby AUTHORIZE the Athletic Commission of the Department of Business and Industry of the State of Nevada (the "Commission"), pursuant to the provisions of NRS/NAC Chapter 467, to RELEASE any and all medical information and/or personal information with respect to my status and licensure as a professional unarmed combatant which may be contained in any of the Commission's records. I further authorize the Commission to release this information to any person whom the Commission determines has a need to know. I agree that I will fully cooperate with the Commission in making my medical history available including, but not limited to, giving oral or written reports to the Commission regarding my medical condition, care and/or treatment.

I further agree that a photographic copy of this Authorization shall be valid as the original.

I further agree that this Authorization will be valid until it expires one (1) year after the expiration of my license on the 31st of December of this year unless I renew my license and sign another Authorization.

_____ _____

Date Signature of Applicant

_____ _____

Location Name Printed